

FILED JAN 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **42623**
11460

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN University City,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSPITAL				e. STREET ADDRESS (If rural, give location) 714la Amherst Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) LILLIE b. (Middle) B. c. (Last) SILVERSTEIN			4. DATE OF DEATH (Month) (Day) (Year) DEC-28-1955				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH SEPT. 27, 1895	
9. AGE (In years last birthday) 60.0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Meyer Brockman			13b. MOTHER'S MAIDEN NAME Goldie Schwartz			14. NAME OF HUSBAND OR WIFE Abe Silverstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mr. Abe Silverstein ADDRESS 714la Amherst.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pyelonephritis with multiple abscesses. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adenocarcinoma of Fallopian tube with metastases to peritoneal cavity & pelvis. DUE TO (c) Recurrent ascites.					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 7/21/55		19b. MAJOR FINDINGS OF OPERATION Fallopian tube with metastases to uterus & peritoneal cavity -				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 175X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 5/19 , 1955, to 12/28 , 1955, that I last saw the deceased alive on 12/29 , 1955, and that death occurred at 4:10A m., from the causes and on the date stated above.							
23a. SIGNATURE Hein Foster mds. (Degree or title) _____				23b. ADDRESS 727 No. Locust Blg.		23c. DATE SIGNED 12/29/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/29/55		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County Missouri	
DATE REC'D BY LOCAL REG. DEC 29 1955		REGISTRAR'S SIGNATURE Carl Smith mds		25. FUNERAL DIRECTOR'S SIGNATURE Herman Rindskopf Inc. ADDRESS 5216 Delmar Bl.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Peter B. Dubouille*

Licensed Embalmer No. *369*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.